Health Neighborhoods 101
July 30, 2013

Connecticut Department of Social Services

Making a Difference

Today's Agenda

- Overview

- Context
  - Centers for Medicare and Medicaid (CMS) Triple Aim
  - CMS integrated care and shared savings initiatives
  - Connecticut Medicaid reforms

- Key features of Integrated Care Demonstration
  - Philosophy
  - Goals
  - Profile of population to be served
  - Structure

Overview

What is a health neighborhood (HN)?

- As conceptualized, HNs are the framework of an innovative health care delivery model through which local systems of care will be accountable for improving health outcomes and the care experience for eligible Medicare-Medicaid enrollees (MMEs)

- HNs will be rewarded for providing better value over time

Overview

What is a health neighborhood (HN)?

- HNs will be made up of a broad array of providers, including primary care and physician specialty practices, behavioral health providers, long-term services and supports providers, hospitals, nursing facilities, home health providers, and pharmacists

Overview

Why are we talking about health neighborhoods (HNs)?

- In partnership with the Departments of Mental Health and Addiction Services (DMHAS) and Developmental Services (DDS), the Department of Social Services (DSS) is planning to implement the Centers for Medicare and Medicaid Innovation (CMMI) Demonstration to Integrate Care for Medicare-Medicare Enrollees for eligible MMEs age 18-64, and age 65 and older

Overview

Why are we talking about health neighborhoods (HN)? (cont.)

- Connecticut was awarded a $1 m. grant from CMMI in 2011 that supported a broad stakeholder planning process in support of this Demonstration

- The planning process has been overseen by the Complex Care Committee of the state Medical Assistance Program Oversight Council (MAPOC)

Overview

Why are we talking about health neighborhoods (HN)? (cont.)

- Connecticut submitted an application for implementation funding in April, 2013
- Connecticut is currently negotiating a Memorandum of Understanding (MOU) with CMMI

Overview

Why are we talking about health neighborhoods (HNs)? (cont.)

- The Demonstration will seek to improve MMEs' health and care experience outcomes by integrating Medicare and Medicaid long-term care, medical and behavioral services and supports, promoting provider practice transformation, and creating pathways for information sharing

Overview

Why are we talking about health neighborhoods (HNs)? (cont.)

- The federal government will share a percentage of any Medicare savings that are achieved under the Demonstration, net of an increase in Medicaid spending, with Connecticut

- A portion of these shared savings payments will be paid to participating HN providers who meet identified standards on Demonstration quality measures

Overview

Why are we talking about health neighborhoods (HNs)? (cont.)

- The Department of Social Services (DSS) intends to issue a Request for Proposals (RFP) to procure 3-5 HNs
- DSS is planning to issue the RFP on or about _____.

Overview

Why are we talking about health neighborhoods (HNs)? (cont.)

- This presentation is intended to equip health care providers with an understanding of the Demonstration, the needs of eligible beneficiaries, the requirements for serving as a HN and the role of an HN

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Context

Centers for Medicare and Medicaid (CMS) "Triple Aim":

- improve the health of the population
- enhance the individual's experience of care (quality, accessibility, reliability)
- control the rate of increase in, and where possible reduce, the per capita cost of care

Context

CMS coordinated care initiatives

- Medicare Advantage (MA) plans (capitated)
- Physician Group Practice (PGP) Demonstration

  first CMS pay-for-performance initiative that encouraged physicians to coordinate overall care delivered to Medicare beneficiaries
- 646 Demonstrations (e.g. North Carolina)

  physician/hospital integrated care and pay-for-performance initiative

Context

CMS shared savings initiatives

Model	Performance Incentives
Accountable Care Organization (ACO)	▪**Medicare** savings are shared with MDs and key partners ▪CMS defines value through performance measures ▪Mandatory enrollment (attribution)
Comprehensive Primary Care Initiative	▪**Medicare** savings are shared with MDs only ▪CMS defines value ▪Mandatory enrollment (attribution)
Connecticut's proposed model for Integrated Care Demonstration Health Neighborhoods	•**Net Medicare/Medicaid** savings will be shared with MDs and broad array of providers •CT stakeholders define value •Passive enrollment with opt-out

Context

Connecticut Medicaid reforms:

- **Transition to ASO platform:**
  - Recognizing opportunities to achieve better health outcomes and to streamline administrative costs, Connecticut contracted historically with Administrative Services Organizations (ASOs) to manage its Medicaid behavioral health and dental services (respectively, Value Options and BeneCare)

Context

Connecticut Medicaid reforms (cont.):

- On January 1, 2012, Connecticut expanded this effort by transitioning Medicaid medical services from a managed care infrastructure that included three capitated health plans and a small Primary Care Case Management (PCCM) pilot to a medical ASO: CHN-CT

Context

Connecticut Medicaid reforms (cont.):

- CHN-CT provides a broad range of services, including:
  - member support
  - provider support
  - Intensive Care Management (ICM)
  - predictive modeling based on Medicaid data
  - statewide and provider specific performance measurement and profiling
  - utilization management
  - member grievances and appeals

Context

Connecticut Medicaid reforms (cont.):

- CHN-CT and the behavioral health ASO, Value Options, coordinate in supporting the needs of individuals with co-occurring medical and behavioral health conditions through a co-located behavioral health unit staffed by credentialed individuals

Context

Connecticut Medicaid reforms (cont.):

- **Support for Primary Care:**
  - **Launch of Person-Centered Medical Home (PCMH) pilot:** Effective January 1, 2012, the Department implemented a PCMH pilot to support practices toward certification through NCQA
    - enhanced reimbursement and technical assistance to support practice transformation
    - performance payments for achieving benchmarks on identified measures

Context

Connecticut Medicaid reforms:

- **Support for Primary Care (cont.):**
  - **Implementation of ACA primary care rate increase:** effective July 1, 2013 and retroactive to January 1, 2013, the Department is paying approved, eligible primary care providers 100% of the Medicare rate for identified codes

Context

Connecticut Medicaid reforms:

- **Support for Primary Care (cont.):**
  - **Electronic Health Record (EHR) Funding:** the Department has disbursed over $45 million in Medicaid EHR Incentive Payment Program payments to eligible hospitals and professionals (including physicians, physician assistants, nurse practitioners, certified nurse-midwives, and dentists)

Context

Connecticut Medicaid reforms:

- **“Re-Balancing”**
  - In January, 2013, the Governor, the Office of Policy and Management and the Commissioner of the Department of Social Services released an updated copy of the State’s Strategic Plan to Rebalance Long-Term Services and Supports

Context

Connecticut Medicaid reforms:

- **“Re-Balancing” (cont.)**
  - This plan details diverse elements of a broad agenda that is designed to support older adults, people with disabilities and caregivers in choice of their preferred means, mode and place in which to receive long-term services and supports (LTSS)

Context

Connecticut Medicaid reforms:

- **“Re-Balancing” (cont.)**
  - Key aspects of the plan include 1) continued support for Money Follows the Person; 2) State Balancing Incentive Payments Program (BIPP) activities; 3) nursing home diversification; and 4) launch of a new web-based hub called “My Place”

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Philosophy

The Demonstration is motivated by the concept of **person-centeredness**. The model seeks to empower members by:

- providing the Medicare/Medicaid Eligible individual (MME) with needed information, education and support required to make fully informed decisions about his or her care options and, to actively participate in his or her self-care and care planning;

Philosophy (cont.)

- supporting the MME, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and

- reflecting care coordination under the direction of and in partnership with the MME and his/her representative(s); that is consistent with his or her personal preferences, choices and strengths; and that is implemented in the most integrated setting.

Goals

Through the Medicare Medicaid Eligibles (MME) Initiative, stakeholders and the Departments seek to build on the above-described Medicaid reforms and philosophy of person-centeredness to create and reward innovative local systems of care and supports.

Goals

Improved outcomes are expected to be achieved by:

- integrating medical, behavioral and non-medical services and supports
  - intensive care management
  - contracts and care coordination
  - electronic communication tools and utilization data
- providing financial incentives to achieve identified health and client satisfaction outcomes

Profile of population to be served

- Connecticut MMEs have complex, co-occurring health conditions
  - roughly 88% of individuals age 65 and older has at least one chronic disease, and 42% has three or more chronic diseases
  - 58% of younger individuals with disabilities has at least one chronic disease
  - 38% has a serious mental illness (SMI)

Profile of population to be served (cont.)

- Connecticut MMEs use a disproportionate amount of Medicaid resources and Connecticut is spending much more than the national average on MMEs
  - the 57,568 MMEs eligible for the Demonstration represent less than 10% of Connecticut Medicaid beneficiaries yet they account for 38% of all Medicaid expenditures

Profile of population to be served (cont.)

- per capita Connecticut Medicaid spending for the 32,583 MMEs age 65 and over and the 24,986 MMEs with disabilities under age 65 is **55% higher than the national average**

Profile of population to be served (cont.)

- comparatively high spending alone on MMEs has not resulted in better health outcomes, better access or improved care experience
  - illustratively, in SFY'10 almost 29% of MMEs were re-hospitalized within 30 days following a discharge, and almost 10% were re-hospitalized within 7 days following a discharge

Profile of population to be served (cont.)

- MMEs have reported in Demonstration-related focus groups that they have trouble finding doctors and specialists that will accept Medicare and Medicaid, and often do not feel that the doctor takes a holistic approach to their needs

Structure

- CMS model alternatives:
  - CMS has permitted States to choose between two financial alignment models in support of integrating care for Medicare-Medicaid enrollees:
    - a capitated approach
    - a managed fee-for-service (FFS) approach
  - Connecticut has selected the FFS approach

Structure (cont.)

- Connecticut's Demonstration will feature three key elements:
  - Enhancement of the current Administrative Services Organization (ASO) model
  - Expansion of the PCMH pilot to serve MMEs
  - Procurement of 3-5 "Health Neighborhoods" (HNs)

Structure – Enhanced ASO Model

- Under the Demonstration, CHN-CT will provide extensive technical and other support to HNs, including:
  - use of integrated Medicaid and Medicare data to support enrollment in HNs and to risk stratify MMEs for purposes of HN care coordination
  - member services (e.g. referrals to Medicaid-participating providers, coverage questions)
  - utilization management for Medicaid services

Structure – Enhanced ASO Model

- Under the Demonstration, CHN-CT will provide extensive technical and other support to HNs, including:
  - data analytics to inform practice and assess performance
  - a provider portal to enable HN providers to communicate and to receive data on the individuals that they are serving

Structure – Enhanced ASO Model

- CHN-CT will also support the care coordination needs of MMEs who do not participate in the HN model by tailoring its current Intensive Care Management (ICM) service to meet the needs of MMEs

Structure – Expansion of PCMH Pilot

- Under the Demonstration, the Department will:
  - extend the enhanced reimbursement and performance payments to primary care practices that serve MMEs
  - convert the current enhanced fee-for-service add-on payments to a per member per month (PMPM) payment: the **APM I** payment

Structure – Procurement of HNs

- Under the Demonstration, the Department plans to procure 3-5 HNs:
  - HNs will reflect local systems of care and support and will be rewarded for providing better value over time
  - HNs will be comprised of a broad array of providers, including primary care and physician specialty practices, behavioral health providers, LTSS providers, hospitals, nursing facilities, home health providers, and pharmacists

Structure – Procurement of HNs (cont.)

- HNs will be expected to serve a minimum of 5,000 MMEs
- The Department will provide “cluster analysis” information based on integrated Medicare and Medicaid data to inform formation of HNs
- The cluster analysis will show where there are groups of MMEs served by common sets of providers

Structure – Procurement of HNs (cont.)

- The Demonstration will use a passive enrollment method to engage MME participation in HNs
- MMEs who have received their primary care or behavioral health care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN
- An MME who is passively enrolled will have the choice to opt out of participation

Structure – HN Leadership

- Each HN must identify an " Administrative Lead Agency" that will be responsible for:
  - establishing an integrated service network within its geographic area, linked by care coordination contracts
  - ensuring compliance with contract requirements
  - distributing shared savings dollars to HN providers using a pre-determined distribution methodology

Structure – HN Leadership (cont.)

- in collaboration with a Behavioral Health Partner Agency (BHPA):
  - ensuring adherence to Demonstration care coordination standards and procedures
  - developing a quality improvement program for care coordination
  - collecting and reporting Demonstration data

Structure – HN Leadership (cont.)

- providing or contracting for and monitoring Demonstration supplemental services
- creating forums for core curriculum learning collaborative activities for providers
- developing client education and outreach materials and strategies

Structure – HN Leadership (cont.)

- To serve as an ALA, an entity must:
  - be a Connecticut-based provider of ambulatory healthcare services, with a preference for non-institutional entities
  - have extensive knowledge or expertise in care/case management for Medicare and Medicaid Eligible (MME) individuals

Structure – HN Leadership (cont.)

- have experience providing ambulatory/non-institutional services that reduce the likelihood of institutional care
- have demonstrated experience of data analysis and reporting capability

Structure – HN Composition

- HN must include:
  - primary care providers;
  - identified specialists
  - extender staff
  - behavioral health professionals
  - Access Agency(ies) for the Connecticut Home Care Program for Elders and LMHA or LMHA affiliates that serves the health neighborhood's coverage area
  - occupational, physical and speech/language therapists

Structure – HN Composition (cont.)

- HN must include (cont.):
  - dentists
  - pharmacists
  - community-based long-term services and supports including home health agencies, homemaker-companion agencies, and adult day care centers
  - hospitals that serve the health neighborhood's coverage area
  - nursing facilities
  - hospice providers

Structure – HN Composition (cont.)

- HN may also include:
  - Durable Medical Equipment (DME) providers
  - Emergency Response System (ERS) providers
  - hearing aid providers
  - ophthalmologists

Structure – HN Composition (cont.)

- HNs must also include the following **information & assistance affiliates**:
  - Infoline
  - the CHOICES program that serves the health neighborhood's coverage area
  - the Aging & Disability Resource Center that serves the health neighborhood's coverage area

Structure – HN Composition (cont.)

- HN membership may also include **social services affiliates**, non-exclusive examples of which include:
  - housing organizations
  - home renovation/accessibility contractors
  - bill payment/budgeting services
  - employment services
  - local organizations serving minority, non-English speaking, and underserved populations

Structure – Care Coordination Model

- The most important role of an HN will be to coordinate care for all of its MME members.

- For purposes of the Demonstration, **Care Coordination** is defined as a person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care

Structure – Care Coordination Model (cont.)

- Under the Demonstration, **Lead Care Managers (LCMs)**, employed by **Lead Care Management Agencies (LCMAs),** will be responsible for acting as single points of contact for MMEs who participate in HNs.

- An **LCM** must be an APRN, RN, LCSW, LMFT or LPC and must complete Demonstration training.

Structure – Care Coordination Model (cont.)

- **LCMs** will be responsible for assessing, coordinating and monitoring an MME's Demonstration Plan of Care (POC) for medical, behavioral health, long-term services and supports (LTSS), and social services.

- The Department will make risk-adjusted PMPM care coordination payments directly to **LCMAs** (the **APM II** payment).

Structure - Payments

- Under the Demonstration, the Department will make the following types of payments:
  - **Start-up payments** to support formation of HNs
  - **APM I**: PMPM payment to PCMH practices (replaces current add-on payment)
  - **APM II**: risk-adjusted PMPM payments to Lead Care Management Agencies for care coordination

Structure - Payments

- **Supplemental service payments:** payments to ALAs to contract for supplemental services including nutrition counseling, falls prevention, medication therapy management, peer support and recovery assistant

Structure – Payments

- **Performance payments:**
  - **Year 1:**
    - a portion of actuarially determined savings in aggregate amongst all participating HNs will fund a Performance Payment Pool
    - payments from the pool will be based solely on HN performance on quality measures

Structure - Payments

- **Years 2 & 3:**
  - a portion of actuarially determined savings in aggregate amongst all participating HNs will fund a Quality Bonus Pool and a Value Incentive Pool
  - the Quality Bonus Pool will be distributed based on HN-specific performance against benchmarks (performance incentive payment) and improvement (performance improvement payment) over time
  - the Value Incentive Pool will be distributed to each HN proportionate to its achieved cost savings

Structure – Time Frame for Procurement

- The Department expects to issue the Request for Proposals for HNs on _____.
- Implementation of the Demonstration is expected to be effective on _____.

Questions or comments?